

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by such restrictions.

Education/Training: On occasion, we participate in the education and training of health care professionals. We may use and disclose your medical information to current and prospective students, residents and/or observers as part of the training and educational process.

Example: Your physician may allow a student or observer to monitor your treatment as a part of a learning experience.

Patient Name:

Patient Representative:

Signature:

Date:

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative Acknowledging the receipt of the "Notice of Privacy Practices" for DR2KIDS Medical Group, but was unable to do so, as documented below:

Dated:

Initials:

Reason: